CHILD CARE INJURY REPORT (MEDICAL ATTENTION NEEDED)

State Form 54265 (5-10) / BCC 0221

Return to:
DIVISION OF FAMILY RESOURCES
CHILD CARE . LICENSING -- MS02
402 West Washington Street, Room W361
Indianapolis, Indiana 46204

The information in this document is confidential.

Name of licensee	Date of injury (*month, day, year*)	Time of injury

Address of licensee (*number and street, city, state, and ZIP code*)

Name of child	Age	Sex

Name of parent

Address of parent (*number and street, city, state, and ZIP code*)

Was the injury caused by a fall? ☐ Yes ☐ No	If yes, type of surface:
Did the injury occur on playground equipment? ☐ Yes ☐ No	If yes, type of equipment:

Briefly describe how the injury happened.

Location where the injury occurred

Name of witness to the injury	Child to staff ratio at the time of the injury

Was the child given first aid? ☐ Yes ☐ No	If yes, by whom:

Type of first aid given

Were the parents notified? ☐ Yes ☐ No	If yes, by whom:	If yes, when:

Was emergency treatment provided at the hospital / doctor's office / dentist? ☐ Yes ☐ No	If yes, where:

Result of injury (diagnosis / treatment)

Corrective action taken to prevent further injuries

Signature of licensee	Date (*month, day, year*)